

Evaluating Experimental Policymaking: Lessons from China's Rural Health Reforms

In recent years, much attention has been paid to the Chinese government's experimental approach to developing policy, but few detailed evaluations of the effectiveness of the approach exist. The development of a rural health insurance system in China provides a test case to examine how experimental policy development can work in social and health policy. Faced with the need for multiple simultaneous reforms, which interact in complex ways, policy experimentation may be a way to 'implement the un-implementable' – even in contexts of low and varying implementation capacity. But it must be managed well, and consideration must be given to feedback, policy coordination, and capacity development.

Academic and policy communities are becoming increasingly interested in how the Chinese government uses experimentation in developing policy. Analysts of China's experimental policy-making frequently claim that:

- many reforms start with small-scale policy experiments before proceeding to national roll-out
- experimentation helps avoid major policy mistakes by allowing government to trial controversial measures or develop workable policy solutions in a restricted jurisdiction, minimising risk if the experiment fails
- experimentation is a core component of China's incremental approach to reform, and helps maintain resilience of the health system under reform.

However, there have been few detailed analyses of the effectiveness of such experimental approaches to reform, especially in the area of social and health services, where developing country governments face the challenge of reforming and/or building complex and inter-dependent systems. China is currently reforming its rural health system after many years of neglect and the collapse of key components such as the

rural health insurance system. Does China's experimental approach provide lessons for other developing countries?

Case study: the New Cooperative Medical Scheme

During the planned economy period (1949–1978), China developed a health insurance system, the Cooperative Medical Scheme (CMS), which essentially covered the country's vast rural population and provided low-cost access to basic services and medicines. The CMS was run by villages or communes, but collapsed in most places following the economic reforms that began in the late 1970s. This left rural residents having to pay for treatment and medicines, frequently resulting in impoverishment and/or forgoing of necessary treatment.

Staged reform of the rural health system

Faced with the difficulty of simultaneously reforming multiple components of the health system, one of the starting points chosen by government for reforms in the 2000s was the development of a new rural health insurance scheme, the New Cooperative Medical Scheme (NCMS), which was intended to cover the whole rural population with low-level health insurance by 2010. ➡

Reforms to other parts of the rural health system – such as the management of medical facilities, drug procurement, establishment of monitoring and evaluation (M&E) systems, etc – came after the launch of the health insurance scheme. Crucially, in the early 2000s, medical facilities existed in rural areas throughout China (though many were in a poor state), providing a basis for the development of a functioning rural health system. A number of programmes have focused on strengthening capacity in rural hospitals and clinics.

While the development of the NCMS took into account some of the main lessons from small-scale experiments by academics and international agencies in the 1980s and 1990s, between 2003 and 2008, it was primarily developed through an experimental policy process.

Using pilots and experimental policy design

As with many Chinese policies, central government set the parameters within which sub-national governments should work. Pilots were carried out in approximately 300 counties between 2003 and 2005. Many key elements of scheme design were left to local governments, including amounts of funding, insurance coverage and design of reimbursement plans, and the management of funding and services. Expert teams were convened to help guide county-level pilots, develop training materials on NCMS design, and carry out training for local government officials and NCMS managers. In 2006, a large-scale interim evaluation of the scheme was carried out. This helped inform subsequent policy and promote convergence in policy design.

This method of policy development was intended to:

- allow local governments to adapt the scheme to local conditions
- produce lessons that could contribute to scheme design and promote bottom-up learning in development of a central government policy.

Challenges in this method of policy development include:

- very limited (and variable) capacity in county



Family outside a village pharmacy/clinic in Hu Kou, Shanxi Province.

health administrations tasked with implementing the NCMS

- lack of local-level data on burden of disease and health service utilisation
- reliance on a huge number of implementing units (initially around 300 counties, increasing to around 3,000), making coordination difficult.

Expansion of overall health reforms

By 2008, all counties had established NCMS pilots, though development of the scheme is continuing, especially following the substantial expansion in the scope of China's overall health reforms, which started in 2009. Following the initial decentralised development of the NCMS, however, integration is now taking place: sub-national schemes are being enlarged to cover larger populations and spread risk; reimbursement across provincial schemes (which was previously not possible) is being piloted; and more attention is being paid to cost-effectiveness and provider performance. Since 2009, provider payment reform has been a focus of NCMS development, while the scheme itself – which covers rural residents only – is being integrated with urban health insurance and commercial schemes.

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Emerging lessons on experimental policy development

Limited and varying sub-national capacity need not be a barrier to developing functioning systems

Before 2003 and the launch of the NCMS in China, most county governments had no experience of implementing a health insurance programme and no training in health economics or analytical methods needed for design of benefit packages. Following basic needs analysis and limited inputs of technical assistance, pilot counties were able to learn by trial and error, adjusting benefit packages and scheme design over time. Non-pilot counties were able to learn from the experience of the pilot counties when designing and refining their local schemes.

Capable and motivated local government is important for effective implementation

Initially, pilot counties were chosen based on capability and commitment to the pilot. Central funding for the scheme, while limited, sent a message to local governments that the central government fully backed the reform.

National policies must be designed to allow flexible local management

The starting point of each pilot county varied in terms of its institutions and facilities, levels of capacity, disease profiles, costs, etc. Design of the NCMS allowed local flexibility under a unified central policy mandate. This made local health administrators responsible for tailoring the scheme to reflect local needs – for example, by adjusting reimbursement rates to encourage patients to seek treatment in cheaper, local clinics rather than expensive city hospitals.

Where starting points and institutional capacity vary, managing convergence in policy design is important

Flexible county-level implementation can lead to a variety of outcomes. The health administration at provincial and national levels has an important role to play in evaluating counties' practices and guiding convergence in

policy design through evaluation, training and developing standardised policy recommendations. During the piloting of the NCMS (2003–2005), few national policies were issued; most central government policy on NCMS development was issued between 2006 and 2009, when the scheme was being rolled out and consolidated.

Experimental policy development is not a cure-all; sufficient attention must be paid to referencing existing best practice, the capacity of those responsible for implementation, and how the policy is likely to function in context

Policy experimentation can be used to develop solutions to specific policy problems, but it should not be a substitute for policy design: many elements of policy can (and should) be designed in advance, referencing international best practice where relevant. It is important that experimental policy design does not become a fig leaf for reducing the responsibility of central government and shifting the task of policy development to under-resourced local governments, which have limited capacity.

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Baby held by his grandmother being examined by a doctor at a local clinic in Kunming city, Yunnan Province.

Mark Henley/Panos Pictures

The starting point for any policy development process, and the remit of experimenters, will have a large impact on the resulting policy design. Sufficient attention must be paid to what the policy is expected to accomplish and how it will interact with other institutions, such as other components of the health system. The development of the NCMS largely

ignored cost control and provider payment mechanisms, resulting in escalation of costs; to date, the NCMS has been piloted and rolled out across approximately 3,000 counties, covering around 805 million people, but evaluations have shown that the impact on users' health spending and impoverishment has been limited.

Policy implications

- **Effective national systems can be developed through local pilots**

The NCMS shows that it is possible to develop a complex national social insurance policy by substantially relying on local government trial and error with limited technical inputs, even where capacity is limited and uneven.

- **Experimentation can help 'implement the un-implementable'**

Policy experimentation may be a useful approach for 'implementing the un-implementable', when faced with the need for multiple simultaneous reforms that are likely to interact in complex and unpredictable ways.

- **Experimentation can achieve faster results**

'Quick and dirty' experimental piloting and subsequent standardisation may ultimately be faster than designing policy in advance, especially where policy must be implemented across a huge number of jurisdictions, where capacity for prior technical assistance is limited, and where delaying reform could have significant human consequences (for example, in missed treatments and/or increased impoverishment).

- **Experimentation should not be a substitute for proper planning**

Experimental policy development should not be a substitute for sufficient planning and design, and referencing of existing best practice. Central government should provide resources and training to develop the capacity of those responsible for implementation.



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Further reading

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Credits

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